Prior Authorization

[Refer to WAC 388-531-0200]

What Is Prior Authorization (PA)?

The prior authorization (PA) process applies to covered services and is subject to client eligibility and program limitations. Bariatric surgery is an example of a covered service that requires PA. PA does not guarantee payment. The Department reviews requests for payment for noncovered healthcare services according to WAC 388-501-0160 as an Exception to Rule. For Community Inpatient Psychiatric Inpatient authorization, see Section F of the Department/MPA *Inpatient Hospital Billing Instructions*.

The Department's PA requirements are met through the following authorization processes:

- Limitation extensions (LE);
- Written/fax; and
- Expedited prior authorization (EPA).

> **Note:** In addition to receiving PA, the client must be on an eligible program. For example, a client on the Family Planning Only program would not be eligible for bariatric surgery.

For examples on how to complete a prior authorization, please go to: http://hrsa.dshs.wa.gov/authorization/.

How Does the Department Determine PA?

The Department reviews PA requests in accordance with WAC 388-501-0165. The Department utilizes evidence-based medicine to evaluate each request. The Department considers and evaluates all available clinical information and credible evidence relevant to the client's condition. At the time of the request, the provider responsible for the client's diagnosis and/or treatment must submit credible evidence specifically related to the client's condition. Within 15 days of receiving the request from the client's provider, the Department reviews all evidence submitted and will do one of the following:

- Approve the request;
- Deny the request if the requested service is not medically necessary; or

- Request the provider to submit additional justifying information within 30 days. When the additional information is received, the Department will approve or deny the request within 5 business days of the receipt of the additional information. If the additional information is not received within 30 days, the Department will deny the requested service.

When the Department denies all or part of a request for a covered service or equipment, the Department sends the client and the provider written notice within 10 business days of the date the information is received that:

- Includes a statement of the action the department intends to take;
- Includes the specific factual basis for the intended action;
- Includes references to the specific WAC provision upon which the denial is based;
- Is in sufficient detail to enable the recipient to learn why the department's action was taken;
- Is in sufficient detail to determine what additional or different information might be provided to challenge the department's determination;
- Includes the client's administrative hearing rights;
- Includes an explanation of the circumstances under which the denied service is continued or reinstated if a hearing is requested; and
- Includes example(s) of lesser cost alternatives that permit the affected party to prepare an appropriate response.

"Write or Fax" Prior Authorization (PA)

What is "write or fax" PA?

"Write or fax" PA is an authorization process available to providers when a procedure's EPA criteria have not been met or the covered procedure requires PA. Procedures that require PA are listed in the fee schedule. Procedures that are marked with a # sign are noncovered. The Department does not retrospectively authorize any healthcare services that require PA after they have been provided except when a client has delayed certification of eligibility.

For a list of forms and where to send them, please refer to the Important Contacts section. Forms are available at: http://www1.dshs.wa.gov/msa/forms/eforms.html. Be sure to complete all information requested. The Department returns incomplete requests to the provider.

Limitation Extension (LE)

What is an LE?

LE is an authorization of services beyond the designated benefit limit allowed in Washington Administration Code (WAC) and Department/MPA billing instructions.

> **Note:** A request for a limitation extension must be appropriate to the client's eligibility and/or program limitations. Not all eligibility groups cover all services.

How do I request a LE authorization?

Some LE authorizations are obtained by using the EPA process. Refer to the EPA section pages I.6-I.11 for criteria. If the EPA process is not applicable, an LE must be requested in writing and receive the Department approval prior to providing the service.

The written request must state all of the following:

1. The name and ProviderOne Client ID of the client;
2. The provider's name, ProviderOne Client ID, and fax number;
3. Additional service(s) requested;
4. Copy of last prescription and date of last dispense;
5. The primary diagnosis code and CPT® code; and
6. Client-specific clinical justification for additional services.

For a list of forms and where to send them, please refer to the Important Contacts section.

Expedited Prior Authorization (EPA)

EPA is designed to eliminate the need for written authorization. The Department establishes authorization criteria and identifies the criteria with specific codes, enabling providers to create an EPA number using those codes.

To bill the Department for diagnostic conditions, procedures and services that meet the EPA criteria on the following pages, the provider must **create a 9-digit EPA number.** The first five or six digits of the EPA number must be **870000**. The last 3 or 4 digits must be the code assigned to the diagnostic condition, procedure, or service that meets the EPA criteria (see pages I.6-I.11 for codes). Enter the EPA number on the billing form in *the authorization number field,* or in the *Authorization or Comments* section when billing electronically.

Example: The 9-digit authorization number for a client with the following criteria would be **870000421:**

Client is 11 years of age through 55 years of age and is in one of the "at risk" groups because the client has one of the following:

1) Has terminal complement component deficiencies;
2) Has anatomic or functional asplenia;
3) Is a microbiologist who is routinely exposed to isolates of N. meningitidis; or
4) Is a freshman entering college who will live in a dormitory.

870000 = first six digits of all expedited prior authorization numbers. **421**= last three digits of an EPA number indicating that the above criteria is met.

The Department denies claims submitted without a required EPA number.

The Department denies claims submitted without the appropriate diagnosis, procedure code, or service as indicated by the last three digits of the EPA number.

The billing provider must document in the client's file how the EPA criteria were met and make this information available to the Department on request. If the Department determines the documentation does not support the criteria being met, the claim will be denied.

Note: The Department requires written/fax PA when there is no option to create an EPA number.

Expedited Prior Authorization Guidelines

Documentation

The provider must verify medical necessity for the EPA number submitted. The client's medical record documentation must support the medical necessity and be available upon the Department's request. If the Department determines the documentation does not support the EPA criteria being met, the claim will be denied**.**

Which services require EPA?

The Department requires EPA for services noted in WAC, the Department's billing instructions, and/or fee schedules as needing EPA.

You must complete the Oral Enteral Nutrition Worksheet Expedited Prior Authorization Request, DSHS 13-761, for clients who meet EPA criteria for oral enteral nutrition. The completed form must be kept in the client's chart and a copy sent to the pharmacy or medical vendor supplying the oral enteral nutrition product. This form is available at:
http://www1.dshs.wa.gov/msa/forms/eforms.html

If the client does not meet the EPA criteria, the Oral Enteral Nutrition Worksheet Expedited Prior Authorization Request form, DSHS 13-761, must be completed and sent to a pharmacy or medical vendor supplying the oral enteral nutrition product.

Washington State
Expedited Prior Authorization Criteria Coding List

Code	Criteria	Code	Criteria

Blepharoplasties
CPT: 15822, 15823, and 67901-67908,

630 Blepharoplasty for noncosmetic reasons when *both* of the following are true:

1) The excess upper eyelid skin impairs the vision by blocking the superior visual field;

2) On a central visual field test, the vision is blocked to within 10 degrees of central fixation.

Cochlear Implants
CPT: 69930
Dx.: 389.10-389.18

The Department will only reimburse for cochlear implantation when the products come from a vendor with a Core Provider Agreement with the Department.

Note: Bilateral cochlear implantation requires prior authorization.

423 When **one** of the following is true:

1) **Unilateral cochlear implantation** for adults (age 18 and older) with post-lingual hearing loss and children (age 12 months-17 years) with prelingual hearing loss when all of the following are true:

a) The client has a diagnosis of profound to severe bilateral, sensorineural hearing loss;

b) The client has stimulable auditory nerves but has limited benefit from appropriately fitted hearing aids (e.g., fail to meet age-appropriate auditory milestones in the best-aided condition for young children, or score of less than ten or equal to 40% correct in the best-aided condition on recorded open-set sentence recognition tests;

c) The client has the cognitive ability to use auditory clues;

d) The client is willing to undergo an extensive rehabilitation program;

e) There is an accessible cochlear lumen that is structurally suitable for cochlear implantation;

f) Client does not have lesions in the auditory nerve and/or acoustic areas of the central nervous system; and

g) There are no other contraindications to surgery.

Note: Replacement parts for cochlear implants have been moved to the Hearing Aids & Services Program. Refer to the Department/MPA Hearing Aids & Services Billing Instructions for more information.

Dispensing/Fitting Fees for Glasses
CPT: 92340-92342

615 **Glasses (both frames and lenses) – Due to loss or breakage** for adults – glasses may be replaced only once in a 24-month period (without PA). The provider must document all of the following in the client's record:

1) Copy of current prescription (less than 18 months old); **and**
2) Date of last dispensing; **and**
3) Both frames and lenses are broken or lost.

Note: You do not need an EPA # when billing for children or clients with developmental disabilities.

Code	Criteria	Code	Criteria

Dispensing/Fitting Fees for Frames Only
CPT: 92340-92342

611 **Miraflex Frames** For children when all of the following clinical criteria are met:

1) The client is less than 5 years of age; and

2) The provider has documented the reason(s) that the standard Airway Optical frame is not suitable for the child.

618 **Replacement Frames –Due to loss or breakage:** For adults - lost or broken frames may be replaced when **all** of the following are documented in the client's record:

1) No longer covered under the manufacturer's 1 year warranty; **and**

2) Copy of current prescription demonstrating the medical necessity for prescription eye wear; (see pg. C.3) **and**

3) Documentation of broken or lost frames.

Note: You do not need an EPA # when billing for children or clients with developmental disabilities.

619 **Durable Frames** for adults and children - when the following is documented in the client's record:

1) The client has a diagnosed medical condition that has contributed to two or more broken eyeglass frames in a 12-month period.

620 **Flexible Frames** for adults and children - when the following is documented in the client's record:

1) The client has a diagnosed medical condition that has contributed to two or more broken eyeglass frames in a 12-month period.

Dispensing/Fitting Fees for Lenses Only
CPT: 92340 - 92342

622 **Replacement eyeglass lenses - Due to eye surgery/effects of prescribed medication/diseases affecting vision:** For adults and children - within 2 years of last dispensing when:

1) The client has a stable visual condition (see Definition section); **and**
2) The client's treatment is stabilized; **and**

3) The lens correction must have a 1.0 or greater diopter change between the sphere or cylinder correction in at least one eye; **and**

4) The previous and new refraction must be documented in the client record.

623 **Replacement eyeglass lenses – Due to loss or breakage:** For adults, lost or broken lenses may be replaced when **all** of the following are documented in the client's record:

1) Copy of current prescription (prescription is less than 18 months old); **and**

2) Date of last dispensing (if known); **and**

3) Documentation of lens damage or loss.

Note: You do not need an EPA # when billing for children or clients with developmental disabilities.

624 **Replacement eyeglass lenses – Due to headaches/blurred vision/difficulty with school or work:** For adults and children - within 2 years of last dispensing, for refractive changes (provider error is the responsibility of the provider to warranty their work and replace the lens at no charge) when **all** of the following are documented in the client's record:

1) The client has symptoms e.g., headaches, blurred vision, difficulty with school or work; **and**

Code	Criteria

2) Copy of current prescription (prescription is less than 18 months old for adults); **and**

3) Date of last dispensing, if known; **and**

4) Absence of a medical condition that is known to cause temporary visual acuity changes (e.g. diabetes, pregnancy); **and**

5) A refractive change of at least .75 diopter or greater between the sphere or cylinder correction in at least one eye.

625 **High index eyeglass lenses** for adults and children when **one** of the following is documented in the client's record:

1) A spherical refractive correction of +\- 8.0 diopters or greater; **or**

2) A cylinder correction of +\- 3.0 diopters or greater.

Dispensing/Fitting Fees for Contacts
CPT: 92070, 92310-92317

621 **Replacement Contact Lenses – Due to eye surgery/effects of prescribed medication/diseases affecting vision:** For adults - within 1 year of last dispensing when:

1) The client has a stable visual condition (see Definition section); **and**

2) The client's treatment is stabilized; **and**
3) The lens correction has a 1.0 or greater diopter change in at least one eye between the sphere or cylinder correction; **and**

4) The previous and new refraction are documented in the client record.

Note: You do not need an EPA # when billing for children or clients with developmental disabilities.

627 **Replacement Contact Lenses – Due to loss or breakage**: For adults - once every 12 months when contact lenses are lost or damaged **and** the prescription is less than 18 months old.

Note: You do not need an EPA # when billing for children or clients with developmental disabilities.

Hyperbaric Oxygen Therapy
CPT: 99183
(C1300 is billed for the outpatient facility charge.)

425 When both of the following are true:

1) The diagnosis is 250.70-250.83; and

2) Hyperbaric Oxygen Therapy is being done in combination with conventional diabetic wound care.

Injection, Romiplostim, 10 Micrograms
HCPCS: J2796

1300 **All of the following must apply:**

1) Documented diagnosis of Idiopathic Thrombocytopenic Purpura (ITP);

2) Patient must be at least 18 years of age;

3) Inadequate response (reduction in bleeding) to:

   a. Immunoglobulin treatment; and
   b. Corticosteroid treatment; or
   c. Splenectomy.

4) Prescriber and Client must be enrolled in NEXUS.

Laboratory Testing
CPT: 83900, 83909, 88384, and 88385

1209 Limited to 15 donor screenings when both of the following criteria is met:

Code	Criteria	Code	Criteria

1) The client is undergoing or has had a hematopoietic cell transplant; and

2) The transplant is being done at a Department-approved Center of Excellence.

Placement of Drug Eluting Stent and Device

CPT: C1874, C1875, G0290 and G0291

422 The Department pays for drug eluting stents when:

1) Medically necessary; and
2) One or more of the following criteria are met:

a) Stent diameter of 3 mm or less;
b) Length of stent(s) of longer than 15 mm placed within a single vessel;
c) Stents are placed to treat in-stent restenosis;
d) For patients with diabetes mellitus;or
e) For treatment of left main coronary disease.

Meningococcal Vaccine

CPT: 90734 (Conjugate Vaccine – Menactra®)

421 Client is 11 years of age through 55 years of age and meets in one of the "at risk" groups because the client has one of the following:

1) Has terminal complement component deficiencies;

2) Has anatomic or functional asplenia;

3) Is a microbiologist who is routinely exposed to isolates of N. meningitidis; or

4) Is a freshman entering college who will live in a dormitory.

CPT: 90733 (Polysaccharide vaccine – Menomune®)

424 Client meets at least 1 of the 5 criteria for use of the meningococcal vaccine outlined for EPA code 421 (CPT code 90734) and **one of the following is true**:

1) The client is one of the following:

a) 2 years of age through 10 years of age; or
b) Older than 55 years of age.

2) The conjugate vaccine is not available.

Neuropsychological Testing

CPT: 96118 and 96119

1207 Refer to Section E for criteria.

Orthotics

HCPCS: **L3030**

780 **Foot insert, removable, formed to patient foot.**

One (1) pair allowed in a 12-month period if one of the following criteria is met:

1) Severe arthritis with pain;
2) Flat feet or pes planus with pain;
3) Valgus or varus deformity with pain;
4) Plantar facitis with pain; or
5) Pronation.

Note:

1) If the medical condition does not meet one of the above specified criteria, you must obtain prior authorization by submitting a request in writing to QUS (see *Important Contacts*) or by calling the authorization toll-free number at 800.292.8064.

2) EPA is allowed only one time per client, per 12-month period. It is the provider's responsibility to determine whether the client has already used all EPA in the period allowed under the EPA criteria.

Code	Criteria	Code	Criteria

HCPCS: **L3310 & L3320**

781 **Lift, elevation, heel & sole, per inch.**

Allowed for as many inches as required (has to be at least one inch), for a client with a leg length discrepancy, on one shoe per 12-month period.

HCPCS: **L3334**

782 **Lift, elevation, heel, per inch**

Allowed for as many inches as required (has to be at least one inch), for a client with a leg length discrepancy, on one shoe per 12-month period.

Note:

1) Lifts are not covered for less than one (1) inch.
2) Lifts are only allowed on one (1) pair of client shoes.
3) If the medical condition does not meet one of the above-specified criteria, you must obtain prior authorization by submitting a request in writing to DMM (see *Important Contacts*) or by calling the authorization toll-free number at 800.292.8064.
4) EPA is allowed only one time per client, per 12-month period. It is the provider's responsibility to determine whether the client has already used all EPA in the period allowed under the EPA criteria.

HCPCS: L3000

784 **Foot insert, removable, molded to patient model, "UCB" type, Berkeley Shell, each**

Purchase of one (1) pair per 12-month period for a client 16 years of age or younger allowed if any of the following criteria are met:

1) Required to prevent or correct pronation;

2) Required to promote proper foot alignment due to pronation; or

3) For ankle stability as required due to an existing medical condition such as hypotonia, Cerebral Palsy, etc.

Note:

1) If the medical condition does not meet one of the above-specified criteria, you must obtain prior authorization by submitting a request in writing to QUS (see *Important Contacts*) or by calling the authorization toll-free number at 1-800-292-8064.

2) EPA is allowed only one time per client, per 12-month period. It is the provider's responsibility to determine whether the client has already used all EPA in the period allowed under the EPA criteria.

3) If the client only medically requires one orthotic, right or left, prior authorization must be obtained.

HCPCS: L3215 or L3219

785 **Orthopedic footwear, woman's or man's shoes, oxford.**

Purchase of one (1) pair per 12-month period allowed if any of the following criteria are met:

1) When one or both shoes are attached to a brace;

2) When one or both shoes are required to accommodate a brace with the exception of L3030 foot inserts;

3) To accommodate a partial foot prosthesis; or

4) To accommodate clubfoot.

Note:

The Department does not allow orthopedic footwear for the following reasons:

1) To accommodate L3030 orthotics;
2) Bunions;
3) Hammer toes;
4) Size difference (mismatched shoes); or
5) Abnormal sized foot.

Code	Criteria	Code	Criteria

Reduction Mammoplasties/ Mastectomy for Gynecomastia
CPT: 19318, 19300
DX: 611.1 and 611.9 only

241 A female with a diagnosis for ***hypertrophy of the breast*** with:

1) Photographs in client's chart, *and*

2) Documented medical necessity including:

   a) Back, neck, and/or shoulder pain for a minimum of one year, directly attributable to macromastia, *and*

   b) Conservative treatment not effective; *and*

3) Abnormally large breasts in relation to body size with shoulder grooves, *and*

4) Within 20% of ideal body weight, *and*

5) Verification of minimum removal of 500 grams of tissue from each breast.

242 A male with a diagnosis for **gynecomastia**:

1) Pictures in clients' chart, *and*

2) Persistent tenderness and pain, *and*

3) If history of drug or alcohol abuse, must have abstained from drug or alcohol use for no less than one year.

Other Reduction Mammoplasties/ Mastectomy for Gynecomastia for a Male or Female with Diagnosis of 611.1 Or 611.9

CPT®: 19300 and 19318

250 Reduction mammoplasty or mastectomy, not meeting expedited criteria, but medically necessary/medically appropriate in accordance with established criteria. Evidence of medical appropriateness must be clearly evidenced by the information in the client's medical record.

Strabismus Surgery
CPT: 67311-67340
DX: 368.2

631 Strabismus surgery for clients 18 years of age and older when *both* of the following are true:

1) The client has a strabismus-related double vision (diplopia), ICD-9-CM diagnosis code 368.2; and

2) It is not done for cosmetic reasons.

Visual Exam/Refraction (Optometrists/Ophthalmologists only)
CPT: 92014-92015

610 **Eye Exam/Refraction - Due to loss or breakage:** For adults within 2 years of last exam when no medical indication exists and **both** of the following are documented in the client's record:

1) Glasses that are broken or lost or contacts that are lost or damaged; **and**

2) Last exam was at least 18 months ago.

Note: You do not need an EPA # when billing for children or clients with developmental disabilities.

Department-Approved Centers of Excellence (COE)

[Refer to WAC 388-531-0650]

The Department pays for medically necessary transplant procedures only for eligible Department clients who are not otherwise subject to a managed care organization (MCO) plan. Clients eligible under the Alien Emergency Medical (AEM) program are not eligible for transplant coverage.

The Department covers the following transplant procedures when the transplant procedures are performed in a hospital designated by the Department as a "center of excellence" for transplant procedures and meet that hospital's criteria for establishing appropriateness and the medical necessity of the procedures:

- Solid organs involving the heart, kidney, liver, lung, heart-lung, pancreas, kidney-pancreas and small bowel.

- Non-solid organs include bone marrow and peripheral stem cell transplants.

The Department pays for skin grafts and corneal transplants to any qualified hospital when medically necessary.

The Department pays for organ procurement fees and donor searches. For donor searches, CPT codes 86812-86822 are limited to a maximum of 15 tests total for human leukocyte antigens (HLA) typing per client, per lifetime. The Department requires PA for more than 15 tests. Use the recipients ProviderOne Client ID when billing for these donor services. To bill for donor services, use the appropriate V59 series diagnosis code as the principal diagnosis code. For example, if billing a radiological exam on a potential donor for a kidney transplant, bill V59.4 for the kidney donor and use V70.8 as a secondary diagnosis-examination of a potential donor. Refer to WAC 388-531-1750, 388-550-1900, 388-550-2100, and 388-550-2200.

Note: Use of V70.8 as a principal diagnosis will cause the line to be denied.

The Department does not pay for experimental transplant procedures. In addition, the Department considers as experimental those services including, but not limited to, the following:

- Transplants of three or more different organs during the same hospital stay;

- Solid organ and bone marrow transplants from animals to humans; and

- Transplant procedures used in treating certain medical conditions for which use of the procedure has not been generally accepted by the medical community or for which its efficacy has not been documented in peer-reviewed medical publications.

The Department pays for a solid organ transplant procedure only once per a client's lifetime, except in cases of organ rejection by the client's immune system during the original hospital stay.

The following services must be performed in a Department-approved Center of Excellence (COE) and **do not require prior authorization (PA)**. See the next page for a list of COEs.

Sleep studies (CPT codes 95805, 95807-95811). Refer to WAC 388-531-1500 and 388-550-6350.

Bariatric Surgery must be performed in a Department-approved hospital and **requires PA**.

Providers must bill with their approved COE facility NPI using the following billing guidelines:

- Electronic billers (837p) must put the COE approved facility NPI in the Comments field of the electronic claim.

- Paper billers must put the COE approved facility NPI in field 32 on the CMS-1500 claim form.

Note: When private insurance or Medicare has paid as primary insurance and you are billing the Department as secondary insurance, the Department does not require PA or that the transplant, sleep study, or bariatric surgery be done in a Center of Excellence or Department-approved hospital.

Services Performed in Department-Approved Centers of Excellence (COE) [Refer to WAC 388-531-0650]

To view the Department-Approved Centers of Excellence list for both Sleep Study and Transplant Centers of Excellence visit the Department on line at:
http://hrsa.dshs.wa.gov/HospitalPymt/

Department-Approved Sleep Study Centers

[Refer to WAC 388-531-1500 and 388-550-6350]

Providers must:

- Use CPT codes 95805 and 95807-95811 for sleep study services.
- Enter the approved Department sleep center's NPI where the sleep study/polysomnogram or multiple sleep latency testing was performed. (Refer to previous page for appropriate location of Department-approved sleep center.) Enter the COE NPI in box 32 on the CMS-1500 Claim Form. When billing electronically, note the COE NPI in the *Comments* section.
- Obtain an ENT consult for children younger than 10 years of age prior to study.
- Sleep studies are limited to rule out obstructive sleep apnea or narcolepsy.

The following is a list of approved diagnoses for sleep studies:

327.10	327.20	327.27	780.51
327.11	327.21	327.42	780.53
327.12	327.23	327.51	780.54
327.14	327.26	347.00-347.11	780.57

Note: When billing on a paper CMS-1500 claim form, note the COE NPI in field 32. When billing electronically, note the COE NPI in the *Comments* section.

Sleep Center Physician Consultations and Referral for Cognitive Behavioral Therapy (CBT)

The Department requires a sleep consultation with a physician who is Board Certified in Sleep Medicine at a Department-approved Sleep Center for any eligible client receiving more than six months of continuous nightly use of any of the following insomnia drugs:

- Generic Zolpidem, Ambien®, Ambien CR®
- Sonata®
- Lunesta®
- Rozerem®

Continuous nightly use of the above insomnia drugs may be necessary for some clients, but it may not be appropriate for others. The Department covers the following drugs without prior authorization within the following limits:

Drug	Limitations
Rozerem®	30 tablets/30 days for maximum of 90 days of continuous use
Generic Zolpidem, Ambien®, Ambien CR®, Sonata®, and Lunesta®	30 tablets/30 days for first fill, then 10 tablets/30 days

The Department will send a letter to the prescribing provider and the client when a sleep consultation is required, and a referral for cognitive behavioral therapy (CBT) may be recommended.

Department-Approved Bariatric Hospitals and Their Associated - Clinics [WAC 388-531-1600 and 388-550-2301]

Department-Approved Bariatric Hospital and Associated Clinics	Location
Sacred Heart Medical Center, Rockwood Bariatric Specialists	Spokane, WA
University of Washington Medical Center, University of Washington Specialty Surgery Center	Seattle, WA
Oregon Health Science University, OHSU Surgery Center	Portland, OR

The Department covers medically necessary bariatric surgery for clients ages 21 to 59 in an approved hospital with a bariatric surgery program in accordance with WAC 388-531-1600. Prior authorization is required. To begin the authorization process, providers should fax the Department a completed "Bariatric Surgery Request" form, DSHS # 13-785 (see Important Contacts).

The Department covers medically necessary bariatric surgery for clients ages 18-20:

- For the laparoscopic gastric band procedure (CPT code 43770);
- When prior authorized;
- When performed in an approved hospital with a bariatric surgery program; and
- In accordance with WAC 388-531-1600.

Bariatric Case Management Fee

For dates of service on and after January 1, 2010, the Department may authorize up to 34 units of a bariatric case management fee as part of the Stage II bariatric surgery approval. One unit of procedure code G9012 = 15 minutes of service. Prior authorization is required.

This fee is given to the primary care provider or bariatric surgeon performing the services required for Bariatric Surgery Stage II. This includes overseeing weight loss and coordinating and tracking all the necessary referrals, which consist of a psychological evaluation, nutritional counseling, and required medical consultations as requested by the Department.

Clients enrolled in a managed care organization (MCO) are eligible for bariatric surgery under fee-for-service when prior authorized. Clients enrolled in an MCO who have had their surgery prior authorized by the Department and who have complications following bariatric surgery are covered fee-for-service for these complications 90 days from the date of the Department-approved bariatric surgery. The Department requires authorization for these services. Claims without authorization will be denied.